MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

237x 92C 0693

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest Town) OR TOWN Davidsonville; LENGTH OF STAY (in this place) ~~Since Born~~; HOSPITAL OR INSTITUTION OR STREET ADDRESS Louis Waysais Farms

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Davidsonville; STREET ADDRESS (If rural give location) Louis Wayson Farm.

3. NAME OF DECEASED (Type or Print): (First) Alice (Middle) (Last) Abrams

4. DATE OF DEATH: (Month) Jany. (Day) 18 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, ~~MARRIED, WIDOWED, DIVORCED~~, (Specify)

8. DATE OF BIRTH: Aug. 31 1937

9. AGE last birthday: 9 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Josiah Abrams

14. MOTHER'S MAIDEN NAME: Madeline Rawlings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Madeline Abrams

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Cardiac Failure	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Tumor of Brain	5 Months
	(c) Chronic Rheumatic Endocarditis	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

make a Postmortem Examination January 18. 1949

22. I hereby certify that I ~~attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19.....~~ and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE Elmer M. Caffey (Degree or title) M.D. ADDRESS Deputy Medical Examiner, Annapolis Md DATE SIGNED 1-18-49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) DATE Jan 20 1949 NAME OF CEMETERY OR ~~CREMATORY~~ Davidsonville Cem LOCATION (City, town, or county) (State) Davidsonville A A Md

DATE REC'D BY LOCAL REG. Jan. 19, 1949 REGISTRAR'S SIGNATURE Carrie Smith Received 1-20-49

24. FUNERAL DIRECTOR ADDRESS H. A. Hardesty + Son

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 24 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0094

353.3
1860

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Annapolis Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Davidsonville Wash. D.C.; STREET ADDRESS (If rural, give location) 1654 EUCLID ST N.W. Wash D.C.

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Israel (Last) Applestine

4. DATE OF DEATH: (Month) Jany (Day) 22 (Year) 19 49

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: ABT. 1878

9. AGE last birthday: 71 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SAND + GRAVEL BUS

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): RUSSIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ISAAC

14. MOTHER'S MAIDEN NAME: BELLA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: EMANUEL F. APPLESTINE – SON

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Fracture of skull — Interval between onset and death: 6 hours

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Epilepsy — unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): accident

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): In front of Court House

CITY OR TOWN: Annapolis (COUNTY): A.A. (STATE): Md

TIME OF INJURY (Month) (Day) (Year) (Hour): Jany 22 1949 9:30 a.m.

INJURY OCCURRED While at Work ☐ Not While at work ☑

HOW DID INJURY OCoccur? Had epileptic seizure – Fell and hit head on concrete

22. I hereby certify that I attended the deceased from Jany 19 to Jany 22, 19 49, ~~that I last saw the deceased alive on ..... 19 ....~~, and that death occurred at 3:50 p.m., from the causes and on the date stated above. Did a Post mortem Examination

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Claffey, M.D. Deputy Medical Examiner, Annapolis Maryland 1/22/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 1-24-49

NAME OF CEMETERY OR CREMATORY: Beth Tfiloh

LOCATION (City, town, or county) (State): Windsor Mill Rd.

DATE REC'D BY LOCAL REG.: 1-24-49

REGISTRAR'S SIGNATURE: C. W. Hedrick

24. FUNERAL DIRECTOR: Jack Lewis Inc

ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

175
49a

0095

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:
County Anne Arundel
City or town Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 years
Hospital, institution, or street address where death occurred:
#3 Main Ave.
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
Street No. #3 Main Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME ALICE E. ARMSTRONG

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife E. Chandler Armstrong
6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) January 21, 1891

8. AGE: Years	Months	Days	If less than one day
57	11	16	.....hrs. .....min.

9. Birthplace Evansville, Indiana
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Harvey F. Hitch
13. Birthplace Evansville, Indiana

MOTHER
14. Maiden name Margaret Griffin
15. Birthplace Kentucky

16. Informant E. Chandler Armstrong
Address Glen Burnie, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 7, 1949 (month) (day) (year)
Cemetery or crematory Woodlawn
Location Baltimore, Maryland

18. Funeral director Thomas W. Singleton
Address Glen Burnie, Maryland

19. 1/6 19 49 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5, 1949 at 5:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN. 4 1949 to JAN. 5 1949 and that I last saw her ER alive on JAN. 5 1949

Immediate cause of death	DURATION
PULMONARY EDEMA	
Due to METASTATIC CARCINOMA	
Due to PRIMARY CARCINOMA OF OVARY	
Other conditions CARCINOMATOSIS (Include pregnancy within 3 months of death)	

Major findings of operation METASTATIC CARCINOMA FROM OVARY Date of op. OCT. 1948
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE F. X. Paul Tinker M. D. or other
Address Glen Burnie, Md. Date signed 1/6/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

448
932

0096

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jessups; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Old Annapolis Ft. Meade Rd. (Herbert Apartments)

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jessups; STREET ADDRESS (If rural give location) (Herbert Apts.) Old Annapolis Ft. Meade Rd.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Francis	Barnes	Atkinson	Jan.	26,	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	W.	Seperated	Oct. 25, 1891	57 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Md. House of Correction

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel K. Atkinson

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: Miss Hazel Marie Brittingham, Jessup, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Haemorrhage	5 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardio-Vascular Disease	1 yr.
	(c) Arterio-sclerosis.	?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 15th, 1948, to Jan. 26, 1949, that I last saw the deceased alive on Jan. 26, 1949, and that death occurred at 7 30 P. m. from the causes and on the date stated above.

SIGNATURE (Degree or title) Frank Shipley, M.D. ADDRESS Savage, Md. DATE SIGNED 1/26/49

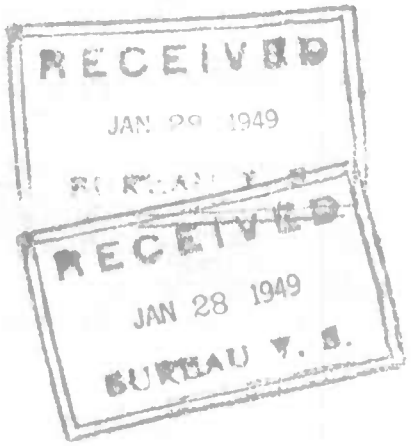
23. BURIAL / CREMATION / REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Jan. 29, 1949	Methodists Cemetery	Snow Hill,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/27/49	[signature]	Clay Dennis	Snow Hill, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15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JAN 28 1949
BUREAU U. S.

0097

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

420.1
94a

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? dead on arrival

Hospital, institution, or street address where death occurred: Annapolis Emergency Hospital

How long in hospital or institution? dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Severna Park
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Alfred Beach

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: K. Ora Beach

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 27, 1892

8. AGE:

Years	Months	Days	If less than one day
56	1	4	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Wm. A. Beach
13. Birthplace: Balto., Md.

MOTHER
14. Maiden name: Cornelius Albert
15. Birthplace: Richmond, Va.

16. Informant: Mrs. K. Ora Beach

Address: Severna Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/4/49 (month) (day) (year)

Cemetery or crematory: Lorraine Cem.

Location: Woodlawn, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 1/3 (Date rec'd by registrar) 19 X9 A.W. Hedrick Dr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany. 1 1949 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~[illegible]~~ from Postmortem Examination ~~and that I last saw him alive on~~ Jany 1, 1949

Immediate cause of death	DURATION
Coronary occlusion	Sudden
Due to Coronary Sclerosis	unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John A. Caffey M.D. Deputy Medical Examiner
M. D. or other

Address: Annapolis Md Date signed 1-1-49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

0098

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

422.1
93d

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Arundel Village
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 6 Months

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Anne Arundel

City or town Arundel Village
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5201 Wasena Ave
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Arthur P. Bradley

3. (b) Social Security Number 705-05-6209

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married —

6.(b) Name of husband or wife Katherine M. Bradley (nee Miller) 6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) May 19, 1896

8. AGE:

Years	Months	Days	If less than one day
52	7	28	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Yard Foreman

11. Industry or business B. & O. R. R. Co.

FATHER
12. Name Charles Bradley
13. Birthplace ?

MOTHER
14. Maiden name Carrie Miller
15. Birthplace ?

16. Informant Mrs. Katherine M. Bradley (Wife)
Address 3710 Annapolis Rd., Balto. 27, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Fri. Jan. 21, 1949 (month) (day) (year)

Cemetery or crematory Moreland Memorial Park Cem.

Location Parkville, Md.

18. Funeral director J. Howard Evans
Address 1400 S. Charles St., Balto. 30, Md.

19. 1/18 1949 (Date rec'd by registrar) H W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mon., Jan. 17, 1949, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 17 1949, to Jan. 1949 and that I last saw him alive on Jan. 17 1949

Immediate cause of death Heart failure due to cardio

Due to vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Rubin M.D.
M. D. or other

Address 203 Palapsco Ave Date signed 1/18/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

025 30b 0099 28

CERTIFICATE OF DEATH

Reg. Dist. No. 50

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (in this place) 20 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Union Bridge
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital	STREET ADDRESS (If rural, give location) ---

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Roland R. Butler

4. DATE OF DEATH (Month) (Day) (Year): January 28, 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	Negro	Married	3/30/1888?	60? yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	-----	Frederick County, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel Butler	Annie Boyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
	unknown	Hospital Records, Crownsville State Hosp.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) General Paresis known to us since 1/8/49

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) none

(c) ---

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. ----

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
---	---	Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
none-accidental	----	------

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
--- m.		-----

22. I hereby certify that I attended the deceased from January 8 1949, to 1/28, 1949, that I last saw the deceased alive on 1/28/, 1949, and that death occurred at 2:15 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Jacob Morgenstern M.D. — Crownsville, Maryland — January 28, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1/30/49	Wesley Cemetary	Liberty Town, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Jany 29/49	Eugene S Bryant	D. D. Hartzler & Sons, New Winsor and Union Bridge, Md.

2-1-49 E. J. Joyce L. Registrar

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RECEIVED
FEB 3 1949
BUREAU V. S.

0100

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1
94a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH · COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Powhatten Beach Pasadena, Md. R.F.D. — LENGTH OF STAY (in this place): 10 Years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Powhatten Beach, Pasadena, Md P.O.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	STREET ADDRESS (If rural give location): Powhatten Beach Road

3. NAME OF DECEASED (Type or Print) (First) JOHN	(Middle) N.	(Last) CAIN	4. DATE OF DEATH (Month) Jan.	(Day) 14	(Year) 1949
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	8. DATE OF BIRTH: May 28, 1876	9. AGE last birthday: 72 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tavern Keeper	10b. KIND OF BUSINESS OR INDUSTRY: Own Business	11. BIRTHPLACE (State or foreign country): Oswego, N.Y.	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME: John Cain		14. MOTHER'S MAIDEN NAME: Mary Sands			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: none	17. INFORMANT: Mrs. Mary Fowler Powhatten Beach, Pasadena, Md. P.O.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — 2 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Senile Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —	19b. MAJOR FINDINGS OF OPERATION: —	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) —	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.	INJURY OCCURRED While at Work ☐ Not While at work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1-49, 19..., to Jan 14-49, 19..., that I last saw the deceased alive on Jan 13-49, 19..., and that death occurred at 6 A. m., from the causes and on the date stated above.

SIGNATURE: Joseph Lipsky M.D. (Degree or title) — ADDRESS: Odenton Md — DATE SIGNED: Jan 15-49

23. BURIAL, CREMATION REMOVAL (Specify): burial	DATE: Jan. 17, 1949	NAME OF CEMETERY OR CREMATORY: Glen Haven	LOCATION (City, town, or county) (State): Glen Burnie, Md.
DATE REC'D BY LOCAL REG.: 1/16/49	REGISTRAR'S SIGNATURE: L. J. De Alba	24. FUNERAL DIRECTOR: Thomas W. Singleton	ADDRESS: Glen Burnie, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 18 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

171 48a

0101

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Crownsville P.O; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ann	Eudora	Carr	1	8	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Married	5-19-1901	47 yrs.	7	19		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Home wife	—	Maryland	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Herbert W. Anderson	Nettie Cadell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Maynard Carr Jr.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uremia	2 wks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of cervix uteri	
	(c) Metastasis	2 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Secondary anaemia — 3 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from March, 1946, to Jan 8, 1949, that I last saw the deceased alive on Jan 8, 1949, and that death occurred at 7 a.m., from the causes and on the date stated above.

SIGNATURE: George C Basil (Degree or title) M.D. ADDRESS: Annapolis DATE SIGNED: Ned

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	1-10-49	St Stephens	A.A.Co Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
	W. T. Lynch	John M. Taylor & Son	

RECEIVED
JAN 13 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0102

153
46 c

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY: ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ANNAPOLIS
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: EMERGENCY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: A.A.Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: EASTPORT, MARYLAND
STREET ADDRESS (If rural, give location): 110 CHESAPEAKE AVE.

3. NAME OF DECEASED (Type or Print): (First) GLENNIS (Middle) O (Last) CHURCHILL

4. DATE OF DEATH: (Month) JAN. (Day) 26 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify): MARRIED

8. DATE OF BIRTH: 1898

9. AGE last birthday: 50 yrs. If under 1 year: Months 11, Days 10, If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER U.S. NAVAL ACADEMY

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): ANNAPOLIS MD.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: WILLIAM G. CHURCHILL

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES
(If year, give war or dates of service): 1 WORLD

16. SOCIAL SECURITY NO.:

17. INFORMANT: GRACE V. CHURCHILL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Lobar Pneumonia - (Post operative).

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma Colon

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Jan 17-49

19b. MAJOR FINDINGS OF OPERATION: Carcinoma Colon

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1949, to Jan 26, 1949, that I last saw the deceased alive on Jan 26, 1949, and that death occurred at 4:57 P m., from the causes and on the date stated above.

SIGNATURE: E Rowland — (Degree or title): MD — ADDRESS: Eastport md — DATE SIGNED: Jan 28/49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify): Burial — DATE: 1/28/49 — NAME OF CEMETERY OR CREMATORY: CEDAR BLUFF — LOCATION (City, town, or county): ANNAPOLIS — (State): MD.

DATE REC'D BY LOCAL REG.: Jan. 28, 1949 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: JOHN H. TAYLOR + SON — ADDRESS: ANNAPOLIS, MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 19 1949
BUREAU V. S.

0103

EVIDENCE FOR CHANGES ITEM #18 IS ON:
FILM No. G 119 MAR 10 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

181
52b

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place) life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Primrose Farm, Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital	STREET ADDRESS (If rural give location) Annapolis, Maryland

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Eleanor Stewart Corner			4. DATE OF DEATH (Month) (Day) (Year) 1- 21- 49 19		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 5, 1893	9. AGE last birthday 55 yrs.	If under 1 year Months 4 Days 3 — If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Stewart			14. MOTHER'S MAIDEN NAME Annie Clark		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)	16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Kenneth R. Corner		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) (b) Papillomas of the bladder (Malignant) 21.1.48 +

Antecedent cause(s) (a) Secondary Anemia. 1/21/49

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (3/9/49 alec) (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 21.1.48	19b. MAJOR FINDINGS OF OPERATION Papilla - Carcinomas of bladder - A.A.C.	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/7/48, 19....., to 1/2/49, 19....., that I last saw the deceased alive on 12, 1949, and that death occurred at 1.15A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Albert L. Anderson — M.D. Annapolis, Md. ADDRESS DATE SIGNED 1/2/49

23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE Jan 23, 1949	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State) Cleveland, Ohio
DATE REC'D BY LOCAL REG. Jan. 23, 1949	REGISTRAR'S SIGNATURE [signature] French	24. FUNERAL DIRECTOR Ben L. Hopping and Son Annapolis, Maryland	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 25 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0104

443

93d

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel
MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Davidsonville
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Davidsonville
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) James (Middle) J (Last) Cox

4. DATE OF DEATH: (Month) 1 (Day) 13 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Oct 18, 1866

9. AGE last birthday: 82 yrs. If under 1 year: Months 2, Days 25, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Cox

14. MOTHER'S MAIDEN NAME: Margaret Tucker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs James King of Davidsonville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Dilatation of Heart	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	unknown
	(c) Hypertensive Cardio-vascular disease	unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

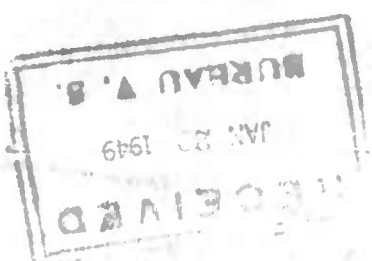
22. I hereby certify ~~that I attended the deceased from~~ I made a Postmortem Examination ....., 19....., to January 13, 1949, ~~that I last saw the deceased alive on~~ ....., 19....., and that death occurred at 4-30 p.m., from the causes and on the date stated above.

SIGNATURE: John M. Claffy, M.D (Title) ~~Deputy~~ Medical Examiner ADDRESS: Annapolis, Maryland DATE SIGNED: 1-15-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 1-17-49
NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
LOCATION (City, town, or county) (State): Washington, D.C.

DATE REC'D BY LOCAL REG.: Jan. 17, 1949
REGISTRAR'S SIGNATURE (Deputy): Jane Smith 1-18-49

24. FUNERAL DIRECTOR: Ben L. Hopping and Son
ADDRESS: 170-172 West St. Annapolis, Maryland


RECEIVED
JAN 27 1949
BUREAU V. S.

0105

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

151
46b

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A. A.

City or town St. Margarets
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 years -

Hospital, institution, or street address where death occurred: no

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town St. Margarets
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME DAVIDSON
Isabel Emory Davidson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband ~~or wife~~ George Davidson

6.(c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) January 30, 1869

8. AGE:

Years	Months	Days	If less than one day
79	11	18	hrs. min.

9. Birthplace Annapolis, Maryland
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business own home

FATHER
12. Name Blanchard Emory
13. Birthplace Queen Anne's Co. Md.

MOTHER
14. Maiden name Mary Bourke
15. Birthplace Queen Anne's County

16. Informant Mrs Isaac Shepherd
Address Harwood, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Jany 20th 1949
(month) (day) (year)

Cemetery or crematory St Margarets

Location St Margarets A A Co Md.

18. Funeral director John M. Taylor Son

Address Annapolis Md.

19. Jan. 19 1949
(Date rec'd by registrar)

[signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 1949 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17 1947 to Jan. 18 1949 and that I last saw her alive on Jany. 12 1949

Immediate cause of death Carcinoma pylorus and of stomach

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emily H. Wilson, M.D.
M. D. or other

Address Cothran, Md. Date signed 1/18/49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 20 1949
BUREAU V. S.

Bc

0106

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

450.0
97

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yr, 6 mos, 13 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 4 yr, 6 mos, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: not known
(If rural, give LOCATION)

2.(a) If veteran, name war: not known

3.(a) FULL NAME: Frederick Douglas

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	widowed

6.(b) Name of husband or wife: not known

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): not known Abt 1871

8. AGE: Years: 78(?) Months: --- Days: --- If less than one day: ____ hrs. ____ min.

9. Birthplace: Maryland Town not known
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: none

FATHER — 12. Name: Soloman Douglas
13. Birthplace: Maryland

MOTHER — 14. Maiden name: not known
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 1, 1949 (month) (day) (year)
Cemetery or crematory: Crownsville Hospital
Location: Crownsville Md

18. Funeral director: Supt Hospital
Address: Crownsville Md

19. 2/6 1949 (Date rec'd by registrar) E.F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22, 1949 19 at 4:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/9/44 19 44 to 1/22/49 19
and that I last saw him alive on 1/22/49 19

	DURATION
Immediate cause of death: General Arteriosclerosis	known to us since 8/9/44
Due to: Senile Psychosis	
Due to:	
Other conditions: *****	

(Include pregnancy within 3 months of death)

Major findings of operations: ******

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Marquette M.D.
M. D. or other

Address: Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
FEB 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.1

0107

CERTIFICATE OF DEATH 108

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH: COUNTY Harman. P. O — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harman. Md — LENGTH OF STAY (in this place) All his life.
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Harman. P.O. COUNTY A.A. Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harman, Md.
STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print): (First) Asa (Middle) (Last) Durner

4. DATE OF DEATH: (Month) Jan. (Day) 21 (Year) 1949

5. SEX: Male. | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married. | 8. DATE OF BIRTH: March 4, 1867 | 9. AGE last birthday: 81 yrs. | If under 1 year: Months. | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): R.R. Track Farmer (Retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): Severn. A.A. Co. Md | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Samuel A. Durner

14. MOTHER'S MAIDEN NAME: Mary Ann Watts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If year, give war or dates of service) —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Asa. Durner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Lobar Pneumonia.	3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio-Vascular Disease, Chronic Arthritis	10 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — | 19b. MAJOR FINDINGS OF OPERATION: — | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): no | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: — | (CITY OR TOWN): — | (COUNTY): — | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1939, to Jan 21, 1949, that I last saw the deceased alive on Jan 21, 1949, and that death occurred at 4:45 P. m., from the causes and on the date stated above.

SIGNATURE: James S. Bellingolia (Degree or title) M.D | ADDRESS: Glen Burnie. Md | DATE SIGNED: Jan 22. 1949.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 1.25.49 | NAME OF CEMETERY OR CREMATORY: Cedar Hill | LOCATION (City, town, or county): Balto. | (State): Md.

DATE REC'D BY LOCAL REG.: 1-24-49 | REGISTRAR'S SIGNATURE: A.W. Hedrick

24. FUNERAL DIRECTOR: WM. J. TICKNER & SONS | ADDRESS: Balto., Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0108

442
1310

Reg. Dist. No. 22

1. PLACE OF DEATH COUNTY Ann Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Ann Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RFD Laurel — LENGTH OF STAY (in this place) 70 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel
HOSPITAL OR INSTITUTION OR STREET ADDRESS None	STREET ADDRESS RFD (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) ~~Annie~~ Marsha (Middle) (Last) Edwards

4. DATE OF DEATH (Month) Jan. (Day) 25 (Year) 1949

5. SEX F.

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Unknown Apr. 1879

9. AGE last birthday about 70 yrs. If under 1 year Months. Days. If under 24 hrs. Hours Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Ann Arundel County

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Ruben Clark

14. MOTHER'S MAIDEN NAME Ann Merrike

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Robert Clark

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bronchopneumonia	3 wks
Antecedent cause(s)	(b) Arteriosclerotic C.V.R disease	5 yrs.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) With Heart & Kidney Failure	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) no

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-19, 1946, to Jan 20, 1949, that I last saw the deceased alive on Jan 20, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE John M. Warren (Degree or title) ADDRESS Laurel A A Co DATE SIGNED Md

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE 1/28/49

NAME OF CEMETERY OR CREMATORY Bacon's Cemetery

LOCATION (City, town, or county) Ann Arundel Laurel (State)

DATE REC'D BY LOCAL REG. Jan 28-1949

REGISTRAR'S SIGNATURE Clara Haslup

24. FUNERAL DIRECTOR W. R. Selby 401 Wash. Blvd. ADDRESS Laurel, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

331

83a

0109

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY A.A. County — MARYLAND
CITY (If outside corporate limits, write RURAL aod give nearest towo) OR TOWN Pasadena
LENGTH OF STAY (in this place) 10yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS High Point

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL aod give nearest town) OR TOWN Pasadena
STREET ADDRESS (If rural, give location) High Point

3. NAME OF DECEASED (Type or Print): (First) LEE (Middle) (Last) EISENRAUCH

4. DATE OF DEATH (Mooth) (Day) (Year): Jan. 23, 1949

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: June 11, 1883

9. AGE last birthday: 65 yrs. (If under 1 year: Months. Days; If under 24 hrs.: Hours Min.)

10a. USUAL OCCUPATION (Give kiod of work done during most of working life, eveo if retired): Cabinet Maker

10b. KIND OF BUSINESS OR INDUSTRY: Boats

11. BIRTHPLACE (State or foreign couotry): Germany

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Anton Eisenrauch

14. MOTHER'S MAIDEN NAME: Marie Schonbauer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no

16. SOCIAL SECURITY No.: 578-07-6380A

17. INFORMANT: Joseph W. Eisenrauch - 1600 Darle y ~~Avenue~~

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage

Antecedent cause(s)

Diseases or conditions, if aoy, giving rise to the above cause statiog the underlying cause last (b) Essential Hypertention

(c) —

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or coodition causing death. (Leg ulcer. 3 yrs)

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1948, to Jan. 23 1949, that I last saw the deceased alive on Jan 23, 1949, and that death occurred at 2 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Dr. Thos. H Phillips 3307 Edmondson Ave 2-9-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: 1/27/49

NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REG. 1-25-49

REGISTRAR'S SIGNATURE: A.W. Hedrick

24. FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC. BALTIMORE, MARYLAND

0110

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

443
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Odenton, (Rural) — LENGTH OF STAY (in this place): 4½ years
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Odenton, (Rural)
STREET ADDRESS (If rural give location): Patuxent Road

3. NAME OF DECEASED (Type or Print): (First) ADDIE (Middle) L. (Last) FIELDING

4. DATE OF DEATH: (Month) Jan (Day) 16 (Year) 1949

5. SEX: Male ? F — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow — 8. DATE OF BIRTH: Mch 4. 1884 — 9. AGE last birthday: 64 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework — 10b. KIND OF BUSINESS OR INDUSTRY: Daughters Home — 11. BIRTHPLACE (State or foreign country): Tennessee — 12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: William Thomas Baker — 14. MOTHER'S MAIDEN NAME: Nancy Elizabeth Jane Hicks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no — 16. SOCIAL SECURITY NO.: Unknown — 17. INFORMANT: Mrs. E.J.Brown, Odenton, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	16 Hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardio-Vascular Disease	15 Years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION: — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED Whila at Work ☐ Not Whila At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 19.46, to Jan 16, 19.49, that I last saw the deceased alive on Jan 15, 19.49, and that death occurred at 5.00 A.m., from the causes and on the date stated above.

SIGNATURE: Edward G Hewitt — (Degree or title) M.D. — ADDRESS: Gambrills Md — DATE SIGNED:

23. BURIAL, CREMATION, REMOVAL (Specify): Ship — DATE: Jan. 18, 1949 — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) (State): Spring City, Tenn.

DATE REC'D BY LOCAL REG.: 1/17/49 — REGISTRAR'S SIGNATURE: E. J. Brown

24. FUNERAL DIRECTOR: Thomas W. Singleton, Glen Burnie Md. — ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.1
932

0111

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mayo
STREET ADDRESS (If rural, give location): Mayo A.A.Co. Maryland

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) ELLEN (Last) GAITHER

4. DATE OF DEATH: (Month) January (Day) 14, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: July 10, 1866

9. AGE last birthday: 82 yrs. — If under 1 year: Months: 7 Days: 4 — If under 24 hrs.: Hours: Mln.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Anne Arundel Co. Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Zachariah Carrick

14. MOTHER'S MAIDEN NAME: Eliza Wedding

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Lyle W. Gaither Mayo, A.A.Co.Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Bronchio-Pneumonia (Terminal)	10 days
Antecedent cause(s)	(Causative organism not isolated)	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis Cardio-Vascular Disease	2 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/1/49, to 1/14/49, that I last saw the deceased alive on 1/14/49 and that death occurred at 3:45 P.M., from the causes and on the date stated above.

SIGNATURE: Albert L. Anderson M.D. (Degree or title) ADDRESS: DATE SIGNED: 1/14/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 1/16/1949 — NAME OF CEMETERY OR CREMATORY: Mayo Memorial Church — LOCATION (City, town, or county) (State): Anne Arundel Co. Maryland

DATE REC'D BY LOCAL REG.: January 16, 1949 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR ADDRESS: John M. Taylor & Son Annapolis, Maryland

RECEIVED
JAN 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.1 93d

0112

CERTIFICATE OF DEATH

Reg. Dist. No. 41

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Benfield (Millersville P.O.) | LENGTH OF STAY (in this place) 38 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crain Highway

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Benfield (Millersville P.O.)
STREET ADDRESS (If rural give location) Crain Highway

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) (none) (Last) Geis

4. DATE OF DEATH: (Month) January (Day) 27 (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Oct. 1, 1864

9. AGE last birthday: 84 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Lorenz H. Bach

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardio-Vascular Disease — 6 mos.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 20, 1948, to Jan 27, 1949, that I last saw the deceased alive on Jan 27, 1949, and that death occurred at 4 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Chas. L. Ballou MD — Linthicum, Md. — Jan 27-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 1-29-49 | NAME OF CEMETERY OR CREMATORY: Cedar Hill | LOCATION (City, town, or county) (State): Brooklyn R.F.D.

DATE REC'D BY LOCAL REG. 1/28/49 | REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: Thomas W. Singleton | ADDRESS: Glen Burnie, Md

RECEIVED
JAN 25 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

025
30b

0113

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10/20/1944

Hospital, institution, or street address where death occurred:
Crownsville State Hopsital

How long in hospital or institution? 10/20/1988

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A.A.C.

City or town: Drur y
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
LOUIS GRIFFIN (GRIFFITH)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) unknown ABT. 1924

8. AGE:

Years	Months	Days	If less than one day
24			... hrs. ... min.

9. Birthplace: drury A.A.C. Md.
(Town, county, and state)

10. Usual occupation: farmer

11. Industry or business

FATHER
12. Name: Louis Griffin sen.
13. Birthplace

MOTHER
14. Maiden name: Florence Griffin
15. Birthplace

16. Informant: Hospital records

Address: CROWNSVILLE STATE HOSPITAL

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: JAN 4 1949 (month) (day) (year) CROWNSVILLE

Cemetery or crematory: Moses Cem

Location: Drury Md A.A. Co.

18. Funeral director: D. A. Hardesty + Son

Address: Galesville Md.

19. 1/3-49 19 (Date rec'd by registrar) E. F. Hogue Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1/49 19 at 5 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10/20/44 19 to 12/31/48 19 and that I last saw h alive on 12/31/48 19

Immediate cause of death: Juvenile general paresis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION: known to us since 10/20/44.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jacob Morgenstern M.D.
M. D. or other

Address Date signed

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1949
BUREAU V. S.

0114

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 113 Spa View Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 5 Cathedral St.

3. NAME OF DECEASED (Type or Print) (First) William (Middle) H. (Last) Hambrock

4. DATE OF DEATH (Month) 1 (Day) 13 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Sept 6, ~~1949~~ 1869
9. AGE last birthday 79 yrs. If under 1 year Months 4 Days 7 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer
10b. KIND OF BUSINESS OR INDUSTRY Gov.
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Frederick Hambrock
14. MOTHER'S MAIDEN NAME unknonw

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Mrs. James A. Coghlan 113 Spa View Ave Annapolis, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	2 hours
Antecedent cause(s)	(b) Coronary Insuffening	3 years
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Arteriosclerosis	3 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-1, 1944, to 1-13, 1949, that I last saw the deceased alive on 1-13, 1949, and that death occurred at 5 p m., from the causes and on the date stated above.

SIGNATURE George C Basil (Degree or title) M D ADDRESS Annapolis DATE SIGNED Md. 1-15-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 1-16-149
NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery
LOCATION (City, town, or county) (State) Annapolis, Maryland

DATE REC'D BY LOCAL REG. Jan. 15, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Ben L. Hopping and Son ADDRESS 170-172 West St. Annapolis, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 18 1949
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

025
30b

0115

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Crownsville, Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos 24 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 6 mos. 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 31 Gott Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ****

3.(a) FULL NAME: Phillip Harris

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife: Florence Harris

6.(c) If alive, give age: ***** years

7. Birth date of deceased (mo., day, yr.): ******* About 1915

8. AGE: Years	Months	Days	If less than one day
34	****	**	hrs. **** min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business: none

FATHER
12. Name: Charles Harris
13. Birthplace: Maryland

MOTHER
14. Maiden name: Minnie (?) Maryland
15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 1/28/49 (month) (day) (year)

Cemetery or crematory: Broadack Cemetery

Location: St. Margaret

18. Funeral director: J. B. Johnson

Address: Annapolis

19. Jan. 26 1949 (Date rec'd by registrar) E F Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/25/49 19 at 4:45A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30, 1948 19 to 1/25/49 19

and that I last saw him alive on 1/25/49 19

Immediate cause of death: General Paresis

Due to:

Due to:

Other conditions: *****

(Include pregnancy within 3 months of death)

DURATION: known to us since March 30, 1948

Major findings of operations: *****

Date of op.

Autopsy results: *****

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D. M. D. or other

Address: Date signed

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

331
830

.0116

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Green Haven (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Outing ave + 2nd Street
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Anne Arundel
City or town Green Haven Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Outing ave + 2nd Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elizabeth Holland

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Edward F. Holland
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): June 16, 1893
8. AGE: Years 55 Months 7 Days 3 If less than one day ____ hrs. ____ min.
9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: House Work
11. Industry or business: —
FATHER 12. Name: Louis Schultz
FATHER 13. Birthplace: Baltimore
MOTHER 14. Maiden name: Kate Schmidt
MOTHER 15. Birthplace: Baltimore
16. Informant: Mrs. Wm. L. May
Address 711 Walnut ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 22 1949 (month) (day) (year)
Cemetery or crematory: Baltimore
Location: East North ave
18. Funeral director: S. Walter May
Address 619 N. Bouldin St. #5
19. 1/20 1949 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19, 1949, at 2 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 18 1949, to Jan. 19 1949, and that I last saw her alive on Jan 19 1949.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to: Hypertension	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: —
Of autopsy: —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thos. F. Phillips M. D. or other
Address 3307 Edmondson Date signed 1-20-49

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0117

331

CERTIFICATE OF DEATH 830

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Annapolis
STREET ADDRESS (If rural, give location): Marbarlane Annapolis Neck

3. NAME OF DECEASED (Type or Print): (First) Edna (Middle) May (Last) HOPKINS

4. DATE OF DEATH: (Month) 1 (Day) 8 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: 5/13/1903

9. AGE last birthday: 45 yrs. — If under 1 year: Months. 9 Days 28 — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Bergeman Rebstock

14. MOTHER'S MAIDEN NAME: Annie Hartzberger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Edgar Hopkins

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	28 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic infectious arthritis	10 years
	(c) Arterio sclerosis & hypertension	4 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jany 8, 1949, to Jany 9, 1949, that I last saw the deceased alive on Jany 9, 1949, and that death occurred at 8 A. m., from the causes and on the date stated above.

SIGNATURE: John M. Clagg M.D. (Degree or title) ADDRESS: Annapolis, Maryland DATE SIGNED: 1-10-49

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify) DATE: 1/13/49 NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Park LOCATION (City, town, or county) (State): Glen Burnie Md.

DATE REC'D BY LOCAL REG.: Jan. 12, 1949 REGISTRAR'S SIGNATURE: W. J. French

24. FUNERAL DIRECTOR: John M. Cagler Son ADDRESS: Annapolis Md.

VS. A15

RECEIVED
JAN 13 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 70

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Davidsonville
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Central Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Davidsonville
STREET ADDRESS (If rural, give location): Central Ave.

3. NAME OF DECEASED (Type or Print): (First) MARIE (Middle) JEANETTE (Last) KING

4. DATE OF DEATH: (Month) Jan. (Day) 31, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: June 30, 1892

9. AGE last birthday: 56 yrs. — If under 1 year: Months 7, Days 1 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas J. Mayhew

14. MOTHER'S MAIDEN NAME: Emma Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no — no

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: J. Irving King Davidsonville, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93.2 (b) arteriosclerotic vascular disease (general)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 30, 1949, to Jan. 31, 1949, that I last saw the deceased alive on Jan. 31, 1949, and that death occurred at 4:05 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Emily H. Wilson, M.D. — Lothian, Md. — Feb. 1, 1949.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Feb. 3, 1949 | NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery | LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: Feb. 3, 1949 | REGISTRAR'S SIGNATURE: Carrie Smith

24. FUNERAL DIRECTOR: B.L. Hopping and Son | ADDRESS: Annapolis, Md.

FILED in Division of Vital Records 11/29/51 A.W. HEDRICH L

RECEIVED
NOV 30 1951
BUREAU V. S.

0120

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

422.1
93d

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County A. A.

City or town Severn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.

Hospital, Institution, or street address where death occurred:

Old Annapolis Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Couoty

City or town Same

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Julian Luzowski

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Divorced

6.(b) Name of husband or wife Mary

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Aug. 16 188[illegible]

8. AGE: Years	Months	Days	If less than one day
66	4		hrs. min.

9. Birthplace Poland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Steel Co.

FATHER 12. Name Brother in law

13. Birthplace Poland.

MOTHER 14. Maiden name Josephine Zalinski

15. Birthplace Poland

16. Informant Helen Nowakowski

Address 138 Meadow Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/10.49 (month) (day) (year)

Cemetery or crematory Sacred Heart of Mary Cemetery

Location German Hill Road

18. Funeral director Mary Weber

Address 401 S. Chester St.

JAN 9 1949 19 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1949 at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1946, to Jan 8 1949 and that I last saw h. in alive on Jan 8 1949

Immediate cause of death	DURATION
Cardio. Vascular Disease	3 yrs.
Due to	
Due to	
Other conditions Arteriosclerosis	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Ball Jr. M. D. or other

Address Linthicum Date signed 1-8-49

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
JAN 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

422.1 93d

0118

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County ANNE ARUNDEL, Co.

City or town ROCK VIEW BEACH

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County ANNE ARUNDEL

City or town ROCK VIEW BEACH

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME CHRISTINA LOCKERMAN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	WIDOWED

6.(b) Name of husband or wife JOSHUA LOCKERMAN

6.(c) If alive, give age ..... D ..... years

7. Birth date of deceased (mo., day, yr.) SEPTEMBER 18, 1855

8. AGE: Years	Months	Days	If less than one day
93			..... hrs. ..... min.

9. Birthplace ANNE ARUNDEL Co. MD.
(Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name MICHAEL HARTMAN
13. Birthplace ANNE ARUNDEL Co, MD.

MOTHER
14. Maiden name UNKNOWN
15. Birthplace "

16. Informant MRS. NOLA COOK

Address RIVIERA BEACH, MD.

17. BURIAL Date thereof 1 / 6 / 49
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory MAGOTHY CHURCH.

Location MOUNTAIN ROAD

18. Funeral director JOHN F. DENNY, INC.

Address 715 LIGHT ST -30

19. 1/5 19 49 BALTIMORE A. W. Hedrick Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 3, 1949 at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 16 1947 to Jan. 3 1949 and that I last saw her alive on Jan. 3, 1949

	DURATION
Immediate cause of death Myocardial Failure -	Instant
Due to Chronic Degenerative Myocarditis; Congestive Failure.	2 yrs
Due to Generalized arteriosclerosis, Senility.	—
Other conditions None.	—

(Include pregnancy within 3 months of death)

Major findings of operation None — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury — Injured at work? —

23. SIGNATURE C. H. Goodwin M.D.
M. D. or other

Address Green Gables, Pasadena, Md. Date signed JAN. 4, 1949.

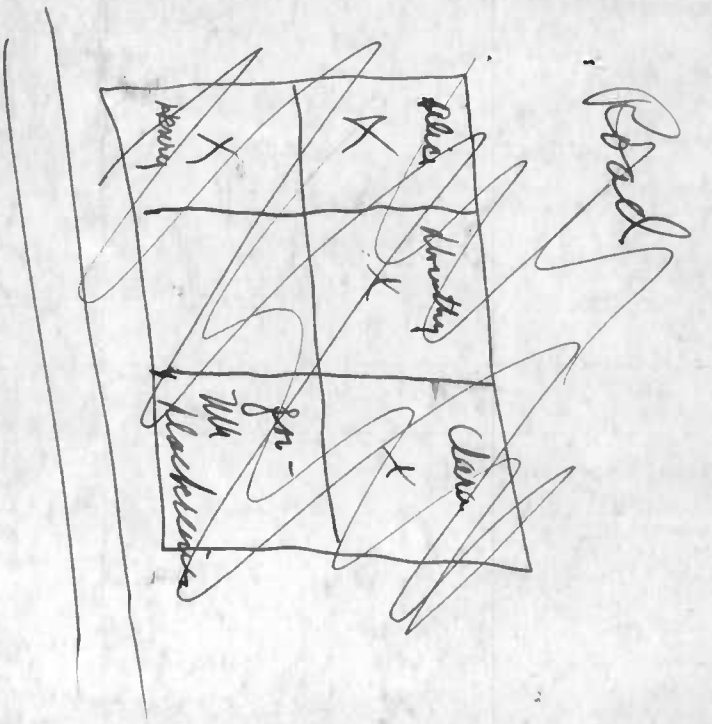
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Road

Alice X	Dorothy X	Clara X
X Henry		for- Mr Mackenzie



0119

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

151
46B

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place) 66 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 12 Hyde Alley	STREET ADDRESS (If rural, give location) 12 Hyde Alley

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) G. (Last) LOWMAN

4. DATE OF DEATH: (Month) 1 (Day) 31 (Year) 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.
MALE	WHITE	SINGLE	10-18-82	66 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LABORER	LABORER	ANNAPOLIS MD	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James LOWMAN	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT
		MARY JANE FAUBLE (BRADY)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hemorrhage	sudden
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of Stomach	1 year
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☑ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended the deceased from~~ made a Postmortem Examination ~~, 19~~ ~~, to~~ Jany 31, 1949, ~~that I last saw the deceased alive on~~ ~~, 19~~, and that death occurred at 4 45 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John M. Caffey M.D.	Deputy Medical Examiner	Annapolis, Maryland	1/31/49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	FEBY 2, 1949	CEDAR BLUFF	ANNAPOLIS MD

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 31, 1949	[signature]	JOHN M. TAYLOR + SON	ANNAPOLIS MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
FEB 1 1949
BUREAU V. S.

EVIDENCE FOR ADDITION ITEM #21 IS ON.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

759.2
109

0121

FILM No. G 119 MAR 10 1949

Reg. Dist. No. 21

1. PLACE OF DEATH:
County ANNE ARUNDEL
City or town ANNAPOLIS
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? LIFE
Hospital, institution, or street address where death occurred:
EMERGENCY HOSPITAL, ANNAPOLIS, MD
How long in hospital or institution? 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ANNE ARUNDEL
City or town ANNAPOLIS
(If outside city or town limits, write RURAL and give nearest town)
Street No. 44 SOUTHGATE AVENUE
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME WILLIAM ANDERSON LYNCH

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept 22nd 1948

8. AGE: Years — Months 3 Days 13 If less than one day ____ hrs. ____ min.

9. Birthplace BALTIMORE City, BALTIMORE, MARYLAND
(Town, county, and state)

10. Usual occupation CHILD

11. Industry or business

FATHER 12. Name William Offley Lynch
13. Birthplace Md

MOTHER 14. Maiden name Dorothy Rose ~~Lynch~~ Anderson
15. Birthplace Annapolis Maryland

16. Informant Mrs Dorothy A. Lynch
Address 44 Southgate Ave. Annap. Md

17. Burial Date thereof Jan 6 1949
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Glen Haven Memorial Park
Location Glen Burnie, Maryland

18. Funeral director John M. Snyder Son
Address Annapolis, Maryland

19. Jan 6 1949 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 JANUARY 1949 at 10 25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 DEC 1948 to 4 JAN 1949 and that I last saw him alive on 4 JAN 1949

Immediate cause of death	DURATION
PNEUMONIA	10 DAYS
Due to, due to	
Due to,	
Other conditions AMYOTONIA CONGENITA [3/9/49 alw]	LIFE

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE Philip Driscoll M. D. or other
Address 212 Prince George St Annapolis Date signed 4 JAN 49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

RECEIVED
JAN 7 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

0122

443

93d

EVIDENCE FOR CHANGE OF AGE + BIRTH DATE IS ON FILM No. G 11, FEB 17 1949

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Ann Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bacon's Chapel near Laurel
LENGTH OF STAY (In this place): 36 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Ann Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bacon's Chapel (Near Laurel)
STREET ADDRESS (If rural, give location): LAUREL - RFD

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Viola	Virginia	Mack	January	22	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	Colored	Married	Aug 19, 1909	39 yrs.	5	3		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Bacon's Chapel near Laurel	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Dave Thomas	Fannie Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		Percy S Mack.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	3 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardiovascular	5 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
	Home	Laurel	A. A.	Md

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan, 1949, to Jan 22, 1949, that I last saw the deceased alive on Jan 22, 1949, and that death occurred at 11:30 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J M Warren	MD	Laurel Md	1/24/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	JAN 26 49	Bacon's Chapel	Near Laurel, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 25. 49	Clara Harlup	Ridgley Selby	401 Main Blvd Laurel, Md

RECEIVED
FEB 10 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 353.3

0123

CERTIFICATE OF DEATH 85

Reg. Dist. No. 27

1. PLACE OF DEATH
COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LAUREL - RURAL
LENGTH OF STAY (in this place) 11 YRS 1 MO
HOSPITAL OR INSTITUTION OR STREET ADDRESS DISTRICT TRAINING SCHOOL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LAUREL - RURAL
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Edward (Middle) (Last) MANDLER

4. DATE OF DEATH (Month) JAN (Day) 31 (Year) 1949

5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) S | 8. DATE OF BIRTH 12-5-99 | 9. AGE last birthday 49 yrs. | If under 1 year Months 1 Days 26 | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | 10b. KIND OF BUSINESS OR INDUSTRY NONE | 11. BIRTHPLACE (State or foreign country) D.C. | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Herman MANDLER | 14. MOTHER'S MAIDEN NAME EVA A. Nee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Dr HUFF - by history of D.T.S.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) EPILEPSY

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. MENTAL DEFICIENCY

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-3, 1937, to 1-31, 1949, that I last saw the deceased alive on 1-31, 1949, and that death occurred at 5-20 P.M., from the causes and on the date stated above.

SIGNATURE R. D. Huff (Degree or title) M.D. ADDRESS Laurel, Md. DATE SIGNED 1/31/49

23. BURIAL, CREMATION, REMOVAL (Specify) Removal | DATE Jan 31, 1949. | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) Washington (State) D.C.

DATE REC'D BY LOCAL REG. Jan 31 1949 | REGISTRAR'S SIGNATURE Clara Haslup | 24. FUNERAL DIRECTOR J. H. Hines Co | ADDRESS 2901-14th St N.W. Wash D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 10 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

7049 / 195a

0124

Reg. Dist. No. 27

1. PLACE OF DEATH:

County: ~~Baltimore~~ Anne Arundel

City or town: Brooklyn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

5209 Brookwood Road, Brooklyn, Md.

How long in hospital or institution? DEAD ON ARRIVAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: West Virginia County: - -

City or town: Morgantown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 800 McLane Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: - - ✓

3. (a) FULL NAME: CLARK NMI MCVICKERS

3. (b) Social Security Number: * *

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4-19-1877

8. AGE: Years	Months	Days	If less than one day
21	8	23	hrs. min.

9. Birthplace: Morgantown, West Virginia.

(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: - -

FATHER

12. Name: Unknown

13. Birthplace:

MOTHER

14. Maiden name: Unknown

15. Birthplace:

16. Informant: Service Record

Address: US Army Ft Geo G. Meade, Md.

17. Removal — Date thereof: Jan 13 49

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Morgantown, W.Va.

18. Funeral director: Derings Funeral Home

Address: Morgantown, W.Va.

19. 14 January 19 49 — E K Burnside

(Date rec'd by registrar) — E.K. BURNSIDE, CAPT., MSC — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 January 19 49 at 1740 hrs M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
massive epidural hematoma right temporal area.	
Due to stellate fracture of right temporal bone of skull.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Unknown — Date of: 12 Jan 49

Where did injury occur? Brooklyn (City or town) Balto (County) C. G. Md. (State)

Injured at home, farm, industry, public place (where?): Unknown

Means of injury: Unknown — Injured at work? Unknown

23. SIGNATURE: Morris J. Lipnik, Capt MC

MORRIS J. LIPNIK, CAPT., M. D. or other MC

Address: ... Date signed: ...

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
JAN 17 1949
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0125

260

CERTIFICATE OF DEATH 61

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PASADENA — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS PASADENA MD

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MD — COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PASADENA
STREET ADDRESS (If rural, give location) PASADENA

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) MILTON (Last) OTTERBINE

4. DATE OF DEATH: (Month) 1 (Day) 29 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) SINGLE

8. DATE OF BIRTH: 5-7-1893

9. AGE last birthday: 55 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WATCHMAN

10b. KIND OF BUSINESS OR INDUSTRY: ARUNDEL SAND Co.

11. BIRTHPLACE (State or foreign country): A.A. Co MD

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: GEORGE OTTERBINE

14. MOTHER'S MAIDEN NAME: LAURA V. DAVIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —

(If year, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT: MRS DANIEL CLARK

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute cardiac failure	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Diabetes mellitus	2 years
	(c) Epilepsy	15 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY —

(CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended the deceased from~~ made a Postmortem Examination, 19, to January 29, 1949, ~~that I last saw the deceased alive on~~, 19, and that death occurred at 4 20 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) John M. Caffey M.D. Deputy Medical Examiner — ADDRESS Annapolis, Maryland — DATE SIGNED 1/31/49

23. BURIAL, ~~CREMATION~~, REMOVAL (Specify) — DATE 2-2-49 — NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk — LOCATION (City, town, or county) Glen Burnie — (State) MD

DATE REC'D BY LOCAL REG. Jan. 31, 1949 — REGISTRAR'S SIGNATURE —

24. FUNERAL DIRECTOR John M. Taylor & Son — ADDRESS Annapolis MD

RECEIVED
FEB 1 1949
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

0126

002
13 b

1. PLACE OF DEATH: COUNTY A.A. Jessups MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Md. House of Correction

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 2806 Terra Firma Rd, CherryHill

3. NAME OF DECEASED (Type or Print) (First) Lloyd (Middle) Columbus (Last) Palin

4. DATE OF DEATH (Month) Jan. (Day) 20 (Year) 1949

5. SEX Male

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH June 29/23

9. AGE last birthday 25 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Palin

14. MOTHER'S MAIDEN NAME Alice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)

16. SOCIAL SECURITY NO. 215-16-1175

17. INFORMANT Patient

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Exhaustion	4 days
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Tuberculosis, pulmonary	
	(c) Generalized	Not Known

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 14 1949, to Jan. 20, 1949, that I last saw the deceased alive on Jan. 20, 1949, and that death occurred at 10:25 P.m., from the causes and on the date stated above.

SIGNATURE John A. Clark (Degree or title) ADDRESS Md. House of Correction DATE SIGNED Physician in Charge - Jessups, Md. Jan. 21/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 1-24-49 NAME OF CEMETERY OR CREMATORY Mt. Calory Cemtery LOCATION (City, town, or county) Balto. md. (State)

DATE REC'D BY LOCAL REG. Jan 24-49 REGISTRAR'S SIGNATURE Clara Haslup

24. FUNERAL DIRECTOR M. B. Spriggs ADDRESS 139 W. Hamburg St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 10 1949
BUREAU V. S.

0127

EVIDENCE FOR CHANGE OF AGE IS ON:

FILM No. G 118 JAN 28 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

443
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 20
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 74 Washington St

3. NAME OF DECEASED (Type or Print) (First) Newton (Middle) (Last) Pinkney
4. DATE OF DEATH (Month) Jan. (Day) 18 (Year) 1949
5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH June 5, 1882
9. AGE last birthday 66 ~~67~~ yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster Shucker
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Annapolis Neck, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Lilm Pinkney
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. 214-05-1748
17. INFORMANT Richard Pinkney

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiac Failure — 4 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio Vascular Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. No

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) No
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home (CITY OR TOWN) Annapolis, Maryland (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-14-49, 19....., to 1-18-49, 19....., that I last saw the deceased alive on 1-18-49, 19....., and that death occurred at 6:45 P.M. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Theodore H. Johnson M.D. ADDRESS 40 Northwest Street Annapolis, Md DATE SIGNED 1/21/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 1-21-49 NAME OF CEMETERY OR CREMATORY Brewer Hill LOCATION (City, town, or county) Annapolis - A.A. (State) Md.

DATE REC'D BY LOCAL REG. Jan. 21, 1949 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR William Reese, II ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 24 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2e

0128

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville; LENGTH OF STAY (in this place) 5 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY [illegible] Co.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; STREET ADDRESS (If rural, give location) 1637 W. Lexington Ave.

3. NAME OF DECEASED (Type or Print): (First) Geneva (Middle) Pitts (Last)

4. DATE OF DEATH: (Month) 1/ (Day) 31 / (Year) 49 19

5. SEX: female

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): divorced

8. DATE OF BIRTH: 1890

9. AGE last birthday: 59 yrs. If under 1 year M[illegible] D[illegible]; If under 24 hrs. Hrs. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laundress

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Oliver

14. MOTHER'S MAIDEN NAME: Janey Perry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) *******

16. SOCIAL SECURITY NO.: ******

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval between onset and death: Sudden Death

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia known since 1/25/44

19a. DATE OF OPERATION: *****

19b. MAJOR FINDINGS OF OPERATION: *****

20. AUTOPSY? ***** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) *****

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) *****

(CITY OR TOWN) ***** (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) ***** (Hour) m.

INJURY OCCURRED While at Work ☐ While At work ☐

HOW DID INJURY OCCUR? *******

22. I hereby certify that I attended the deceased from 1/25/44, 19..., to 1/31/49, 19..., that I last saw the deceased alive on 1/31/49, 19..., and that death occurred at 6:00 A.M., from the causes and on the date stated above.

SIGNATURE Jacob Marquette M.D. (Degree or title) ADDRESS Crownsville, Maryland DATE SIGNED 1/31/49

23. BURIAL, CREMATION, REMOVAL (Specify) burial | DATE 2/4/49 | NAME OF CEMETERY OR CREMATORY Mt Auburn | LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REG. 2/4/49 | REGISTRAR'S SIGNATURE A W Hedrick | 24. FUNERAL DIRECTOR Mrs Kate R Williams | ADDRESS 327 N Schroeder St.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0129

Reg. Dist. No. 28

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (In this place): 4 yr. 11 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore,
STREET ADDRESS (If rural, give location): 550 McMechen Street

3. NAME OF DECEASED (Type or Print): (First) Jesse (Middle) (Last) Reed

4. DATE OF DEATH: (Month) 1/ (Day) 28/ (Year) 1949

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: 1908

9. AGE last birthday: 41 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Elysel Reed,

14. MOTHER'S MAIDEN NAME: Mary Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): ****

16. SOCIAL SECURITY NO.: ***

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Tuberculosis of Lungs — Interval Between Onset and Death: known to us since

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b): — 3/21/44

(c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Dementia Praecox, Mixed Type

19a. DATE OF OPERATION: ******

19b. MAJOR FINDINGS OF OPERATION: ******

20. AUTOPSY? ****** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): *****

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: ****

(CITY OR TOWN) (COUNTY) (STATE): ****

TIME OF INJURY (Month) (Day) (Year) (Hour): ****

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? *****

22. I hereby certify that I attended the deceased from 3/21/44, 19....., to 1/28/49, 19....., that I last saw the deceased alive on 1/28/49, 19....., and that death occurred at 6:00 A.M. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Jacob Mayerstein M.D. — ADDRESS: Crownsville State Hospita, Crownsvills, Md. — DATE SIGNED: 1/28/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 2/1/49 — NAME OF CEMETERY OR CREMATORY: Mt. Calvary — LOCATION (City, town, or county) (State): Anne Arundel

DATE REC'D BY LOCAL REG. 1/31/49 — REGISTRAR'S SIGNATURE: A.W. Hedrick — 24. FUNERAL DIRECTOR: A. Halsted — ADDRESS: Baltimore

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

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13b

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 13 mos. 24 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY B. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore,
STREET ADDRESS (If rural, give location) 1703 W. Lexington Street

3. NAME OF DECEASED (Type or Print) (First) BESSIE RIDDICKE (Middle) (Last)
4. DATE OF DEATH (Month) Jan. 18, (Day) 1949 (Year) 19

5. SEX: famale
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH: 12/22/20
9. AGE last birthday: 28 yrs. If under 1 year: Months Days If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Roscoe Riddicke
14. MOTHER'S MAIDEN NAME: Addie Riddicke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, ~~or unknown~~) ~~(If year, give war or dates of service)~~ *****
16. SOCIAL SECURITY NO. *****
17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Lung Tuberculosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: known to us since 11/8/48

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia, simple type

19a. DATE OF OPERATION *****
19b. MAJOR FINDINGS OF OPERATION *****
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) *****
PLACE OF INJURY (Home, farm, factory, street, office ~~[illegible]~~) (CITY OR TOWN) ******** (COUNTY) (STATE)
TIME OF INJURY (Month) ~~(Day)~~ (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? *****

22. I hereby certify that I attended the deceased from 11/24/47, 19....., to 1/18/49, 19....., that I last saw the deceased alive on 1/18/49, 19....., and that death occurred at 5:00 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Jacob Morgenstern M.D.
ADDRESS Crownsville, Maryland
DATE SIGNED 1/18/49

23. BURIAL, CREMATION REMOVAL (Specify) buried
DATE 1/22/49
NAME OF CEMETERY OR CREMATORY
LOCATION (City, town, or county) (State) Gatesville, N.C.

DATE REC'D BY LOCAL REG. 1/21/49
REGISTRAR'S SIGNATURE S.W. Hedrick DM
24. FUNERAL DIRECTOR Mrs Katie R Williams
ADDRESS 822 N Schroeder St

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0131

332
83b

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Elmhurst (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Anne Arundel

City or town: Severn (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Eliza Ann Robbins

3.(b) Social Security Number: —

4. Sex: F

5. Color or race: B

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Hayes Robins

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Abt. 1856

8. AGE: Years: 92 Months: Days: If less than one day ..... hrs. ..... min.

9. Birthplace: S.C. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: Chas Good
13. Birthplace: S.C.

MOTHER
14. Maiden name: Alice Robbins
15. Birthplace: S.C.

16. Informant: James Robbins

Address: Severn Md. Box 157

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1/5/48 (month) (day) (year)

Cemetery or crematory: Mt Calvary Cemetery

Location: A.A. Co Md

18. Funeral director: Isaiah L Brown Son

Address: 1080 Montgomery St

19. 1/4/49 (Date rec'd by registrar) 19 L. J. DeAlba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 1 1949 at 815 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 27 1948 to Jan 1 1949 and that I last saw her alive on Dec 30 1948

Immediate cause of death: Cerebral Embolism — DURATION: 2 days

Due to

Due to

Other conditions: Senility

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M.D. or other

Address: Odenton Md Date signed: Jan 1-49

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1948
Sp
185-6

RECEIVED
JAN 6 1949
BUREAU V. S.

Dr. Basil.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.1 93d

0132

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis — LENGTH OF STAY (in this place): 45 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 1000 West St.	STREET ADDRESS (If rural give location): 1000 West St

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ida	M	Robbins	1- 19- 49		19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Widowed	Sept 6, 1870	78 yrs.	4	13	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife		Pennsylvinia	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
~~George Robbins~~ C.L. Adams	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
NO		None	Mr. Calvin L. Robbins, Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocarditis Chr. with	2 yrs
Antecedent cause(s)	unfavorable Pneumonia	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis Senile	unknown
	(c) Chronic Hypertension Cerebritis	6 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from ....., 1940, to Jan 19, 1949, that I last saw the deceased alive on 1-18, 1949, and that death occurred at 6 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
George C Basil	M D	Annapolis Md	1-20 49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1- 21- 49	Cedar Bluff Cemetery	Annapolis, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Jan. 21, 1949	[signature]	Ben L. Hopping and Son, Annapolis, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 24 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Bc 450.0 / 131a

0133

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Severna Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Cedar crest N. Home.

How long in hospital or institution? Since 1/6/49

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County:

City or town: Balto

(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 W. Hamburg St.

(If rural, give LOCATION)

2.(a) If veteran, name war: No ✓

3. (a) FULL NAME Harry L. Roberts

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) ~~Single, married,~~ widowed, ~~or divorced~~
M.	White	Widowed

6.(b) Name of ~~husband or~~ wife: Mary C. Roberts

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 21st 1887

8. AGE: Years	Months	Days	If less than one day
61	9	9	..... hrs. ..... min.

9. Birthplace: Balto. Co. Md. (Town, county, and state)

10. Usual occupation: Retired - Gas Maker

11. Industry or business: Gas & Electric Co.

FATHER
12. Name: (Unknown) Roberts
13. Birthplace: Md.

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: Emma K. Broda

Address: 12 W. Hamburg St.

17. Burial (Burial, ~~cremation, or removal~~, Which?) Date thereof: 2/2/49 (month) (day) (year)

Cemetery ~~or crematory~~: Asbury M. E. Church

Location: Reisterstown Md.

18. Funeral director: William Cook Inc.

Address: 1217 St. Paul St.

19. 1/31 19 49 (Date rec'd by registrar) A W Hedrick DM. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30 1949, at 1.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6 1949, to January 29 1949 and that I last saw him alive on 1/29/49 - 19

Immediate cause of death	DURATION
Mitral Insufficiency	Unknown
Due to Interstitial Nephritis	Unknown
Due to General arterio-sclerosis	"
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Gustave H. Paulsen M.D. M. D. or other

Address: Glen Burnie, Md. Date signed: 1/30/49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0134

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

763.0

CERTIFICATE OF DEATH

107 Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Ann Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Ann Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mulberry Hill — LENGTH OF STAY (in this place) 4 hr, 10 min	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mulberry Hill
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rfd 2 Box # 321	STREET ADDRESS (If rural give location) Rfd 2 Box # 321

3. NAME OF DECEASED (Type or Print)	(First) WALTER	(Middle)	(Last) ROSS	4. DATE OF DEATH	(Month) Jan (Day) 6 (Year) 1949
5. SEX MALE	6. COLOR OR RACE COLORED	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Jan 6, 1949	9. AGE last birthday yrs.	If under 1 year Months / Days; If under 24 hrs. Hours 4 Min. 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Charles Ross		14. MOTHER'S MAIDEN NAME Annie Stansbury			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT Annie Stansbury			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Aspiration Pneumonia — 4 hrs 10 min

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) Mulberry Hill (COUNTY) (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 6, 1949, to Jan 6, 1949, that I last saw the deceased alive on Jan 6, 1949, and that death occurred at 62°P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
A. T. Allen	M.D.	10 Carroll St	1-8-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 1-8-49	NAME OF CEMETERY OR CREMATORY Brewer Hill	LOCATION (City, town, or county) (State) Annapolis, Md - A.A
DATE REC'D BY LOCAL REG. Jan. 8, 1949	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR William Reese, II	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 14 1949
BUREAU V. S.

0135

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

420.0

CERTIFICATE OF DEATH

9-1a

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? - - - - - - - - - - - - - -

Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Annapolis, Md.

How long in hospital or institution? 1 day.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 Maryland Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war - - - - - - - - - - - - - -

3. (a) FULL NAME
Erich Herman SCHRADER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Separated.

6.(b) Name of husband or wife Naomi B. SCHRADER

6.(c) If alive, give age - - - years

7. Birth date of deceased (mo., day, yr.) 12 May 1901

8. AGE:	Years	Months	Days	If less than one day
	47	7	8	..... hrs. ..... min.

9. Birthplace New York, N.Y.
(Town, county, and state)

10. Usual occupation U.S. Navy.

11. Industry or business Retired.

FATHER
12. Name Adolph Schrader.
13. Birthplace Germany.

MOTHER
14. Maiden name Martha Wagner.
15. Birthplace Germany.

16. Informant Record Office,
Address U.S. Naval Hospital, Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/13/1949 (month) (day) (year)

Cemetery or crematory Baltimore National

Location Baltimore Maryland

18. Funeral director John M. Taylor Son

Address Annapolis Maryland

19. Jan. 12, 1949 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 January 1949 at 1145 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 January 1949, to 9 January 1949 and that I last saw him alive on 9 January 1949

Immediate cause of death Massive Pulmonary Embolus.

Due to Mural Thrombus, Right Aurical.

Due to Arteriosclerotic Heart Disease. Thromboangitis Obliterans

Other conditions Embolus at Bifurcation of Aorta Occluding Right Common Iliac Artery Completely.
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations ..... Date of op. .....

Autopsy results Findings listed above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R.H. SHEPARD., LTJG, MC, USNR
M. D. or other

Address U. S. Naval Hospital, Annapolis, Md. Date signed 1-10-49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 13 1949
BUREAU F. S.

0136

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

421.1

CERTIFICATE OF DEATH

92a Reg. Dist. No. 20

1. PLACE OF DEATH — COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton — LENGTH OF STAY (in this place) 50 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE Churchton Maryland — COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Perry Te. (Middle) (Last) Scott
4. DATE OF DEATH (Month) Jan (Day) 5 (Year) 1949
5. SEX M.
6. COLOR OR RACE Col
7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH Mar 5 1895
9. AGE last birthday 53 yrs. — If under 1 year: Months 10, Days; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Laborer
11. BIRTHPLACE (State or foreign country) Churchton Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William T. Scott
14. MOTHER'S MAIDEN NAME Alverta Thompson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No. 218-05-3043
17. INFORMANT Roland Scott

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Congestive Heart failure

Antecedent cause(s) (b) Aortic Insufficiency

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) neither
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-3, 1948, to 1-5, 1949, that I last saw the deceased alive on 12-17, 1948, and that death occurred at 8:15 A m., from the causes and on the date stated above.

SIGNATURE A. T. Alley (Degree or title) M.D. ADDRESS 10 Carroll, Annapolis DATE SIGNED 1-5-49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL (Specify)~~ DATE Jan 8 1949 NAME OF CEMETERY ~~OR CREMATORY~~ Franklin Cem LOCATION (City, town, or county) Churchton (State) Md

DATE REC'D BY LOCAL REG. Jan 8th 1949 REGISTRAR'S SIGNATURE M. Clayton Dep'l
24. FUNERAL DIRECTOR F. A. Hardesty & Son ADDRESS Galesville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 10 1949
BUREAU OF

EVIDENCE FOR ADDITIONAL INFO FILM #9119 3-21-49

CERTIFICATE OF DEATH

Registered No. 983 (167)

BIRTH NO. 1882 21 b. 14 F. IS ON

1. NAME OF DECEASED (Type or Print): Perry WILMER Stallings

2. DATE OF DEATH: 1/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Calvert St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Annapolis Md.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Greenock. Md
D. STREET ADDRESS (If rural, give location):

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
M	W	Single	Oct 10, 1916	32		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming	Farming	Edgewater Md	U.S.A.

13. FATHER'S NAME: Robert Plummer Stallings

14. MOTHER'S MAIDEN NAME: Sarah C. Griffith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
no	none

17. INFORMANT: Norval Stallings — ADDRESS: Sudley, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull

DUE TO (B) Intracranial hemorrhage (extradural)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (C) Hit on head with beer bottle

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	Tavern	Churchton, a.a. Co. Md.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	Hit on head with beer bottle

22. *I certify that I took charge of the remains described above, held an* _____ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

Autopsy, Inspection or Inquiry

2/23/49

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐	23C. DATE SIGNED
George A. Merrill M.D.		1/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan 19, 1949	Int Gion Gem	Lothian a.a. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
Jan. 19, 1949	[illegible]	F.E. Hardesty & Son	[illegible]

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING. UNFADING INK. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0138

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Skidmore, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs.
Hospital, institution, or street address where death occurred
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Skidmore
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Stevens

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife Nettie Stevens
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. [illegible] 1891

8. AGE: Years 58 | Months 8 | Days | If less than one day hrs. min.

9. Birthplace Skidmore, Md. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business U.S. Naval Academy

FATHER
12. Name Nelson Stevens
13. Birthplace Skidmore, Md.

MOTHER
14. Maiden name Louise Stevens
15. Birthplace Skidmore, Md.

16. Informant Mrs. Nettie Stevens
Address Skidmore, Md.

17. Burial Date thereof 1 6 49
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Broad Neck
Location Skidmore, Md.
18. Funeral director William Reese, II
Address 108 Washington St. Annap. Md.

19. Jan. 6 1949 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1949, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24 1948, to Jan 3 1949 and that I last saw him alive on Jan 2 1949

Immediate cause of death	DURATION
Cerebro vascular accident.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. T. Allen M. D. or other
Address 10 Conrad Date signed Jan 3, 1949

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 7 1949
BUREAU V. S.

EVIDENCE FOR CHANGE OF AGE IS ON:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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FILM No. G 118 JAN 28 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 2

M

The coverage is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING. Supply every item of information carefully.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

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VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — STATE MARYLAND
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
   LENGTH OF STAY (in this place): life
   HOSPITAL OR INSTITUTION OR STREET ADDRESS: 153 Prince George St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
   STREET ADDRESS (If rural give location): 153 Prince George St.

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) C (Last) Stewart

4. DATE OF DEATH: (Month) January (Day) 18 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 12-29-1869

9. AGE last birthday: 79 80 yrs. If under 1 year: Months 0 Days 19 If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hosue wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Clark

14. MOTHER'S MAIDEN NAME: Margaret Tydings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Mr Kenneth R. Corner Primrose Farm Annapolis, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Dilatation of Heart	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic myocarditis	unknown
	(c) Cardio-vascular disease & hypertension	unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I made a Post mortem Examination January 18. 1949. ~~attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19.....~~; and that death occurred at 8 00 A m., from the causes and on the date stated above.

SIGNATURE: John M. Claffy (Degree or title) M.D. Deputy Medical Examiner, ADDRESS: Annapolis Md — DATE SIGNED: 1-19-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 1-20-49 — NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery — LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: Jan 29 1949 — REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR ADDRESS: Ben L. Hopping and Son Annapolis, Maryland

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JAN 21 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Charles Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 17 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Waldorf
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural give location): none

3. NAME OF DECEASED (Type or Print)	(First) George	(Middle) Harrison	(Last) Stewart	4. DATE OF DEATH	(Month) 1	(Day) 6	(Year) 1949
5. SEX: Male	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: ABT. 1886 (unknown)	9. AGE last birthday: 62(?) yrs.	If under 1 year Months: **	Days: **	If under 24 hrs. Hours, Min.: *******
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): not able to inform us	10b. KIND OF BUSINESS OR INDUSTRY: unknown	11. BIRTHPLACE (State or foreign country): unknown	12. CITIZEN OF WHAT COUNTRY?: United S. (?)				
13. FATHER'S NAME: unknown	14. MOTHER'S MAIDEN NAME: unknown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: *******	17. INFORMANT: Hospital Records					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) General Paresis	known to us
Antecedent cause(s)	******	since 12/21/48
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) ******	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. ******

19a. DATE OF OPERATION: *********	19b. MAJOR FINDINGS OF OPERATION: **********	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify): ****	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ******	(CITY OR TOWN) (COUNTY) (STATE): Crownsville State Hospital
TIME OF INJURY (Month) (Day) (Year) (Hour): ****** m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?: **********

22. I hereby certify that I attended the deceased from 12/21/, 1948, to 1/6/, 1949, that I last saw the deceased alive on 1/6/49, 19....., and that death occurred at 11:37A.M.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title) ADDRESS	DATE SIGNED
Jacob Morgenstern M.D.	Crownsville, Maryland	1/6/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Jan. 10, 1949	NAME OF CEMETERY OR CREMATORY: St. Peter's	LOCATION (City, town, or county): Waldorf, Charles Co	(State): Md.
DATE REC'D BY LOCAL REG.: 1/8/49	REGISTRAR'S SIGNATURE: M. L. Moore	24. FUNERAL DIRECTOR: Hunt & Ryan Philip E. Hunt	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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JAN 10 1949
BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

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CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Inglehart Gambrills
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) CARROLL ROSSITER THOMAS Sr.
4. DATE OF DEATH (Month) (Day) (Year) Jany. 10 1949

5. SEX Male
6. COLOR OR RACE White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify)
8. DATE OF BIRTH Sept. 12, 1887
9. AGE last birthday 61 yrs. If under 1 year: Months 3, Days 28; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Mary Lindsay Mad U.S. Post Office Fort Meade Md
10b. KIND OF BUSINESS OR INDUSTRY Post Office
11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Nelson Thomas
14. MOTHER'S MAIDEN NAME Caroline Stolpp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If year, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Mrs. Clyde Joyce Thomas

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute myocardial infarction	1 day
Antecedent cause(s)	(b) Chronic myocarditis	1 year
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) general arteno-sclerosis	unknown

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jany 9, 1949, to Jany 10, 1949, that I last saw the deceased alive on Jany. 10, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE John M. Caffey (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED 1-11-49

23. BURIAL, CREMATION REMOVAL (Specify) Cremation
DATE 1/13/49
NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory
LOCATION (City, town, or county) Prince Geo. Co. (State) Md.

DATE REC'D BY LOCAL REG. Jan. 12, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
JAN 13 1949
BUREAU V. S.

0142

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

493

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CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred: 33 Hutton Place

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No.: 33 Hutton Place (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John Henry Thomas

3. (b) Social Security Number: none

4. Sex: male

5. Color or race: negro

6.(a) Single, married, widowed, or divorced: ✓

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): (Unknown) ABT 1869

8. AGE: Years: about 80 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Welfare Board

Address: Maryland Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1/8/48 (month) (day) (year)

Cemetery or crematory: Asbury Cemetery

Location: Smithville

18. Funeral director: Mrs. Charles E. Hicks

Address: 43-45 Northwest St.

19. Jan. 8, 1949 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany. 5, 1949, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated: [redacted] Postmortem Examination [redacted] Jany. 5, 1949.

Immediate cause of death	DURATION
Hypostatic Pneumonia	4 days
Due to	
Due to	
Other conditions: Starvation + neglect	6 weeks

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: John M. Caffey M.D. Deputy medical examiner M.D. or other

Address: Annapolis Md Date signed: 1-5-49

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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JAN 14 1949
BUREAU V. S.

Group #1 (Page 43)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

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0143

Reg. Dist. No. L47 47

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Pumphrey (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred: 242 Bishop Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Pumphrey (If outside city or town limits, write RURAL and give nearest town)

Street No.: 242 Bishop Ave (If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Steven Thomas

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	M

6.(b) Name of husband or wife: Emma Thomas

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): 1867

8. AGE:

Years	Months	Days	If less than one day
81	?	?	hrs. min.

9. Birthplace: Anne Arundel Co Md. (Town, county, and state)

10. Usual occupation: Labor

11. Industry or business

FATHER
12. Name: Steven Thomas
13. Birthplace: ?

MOTHER
14. Maiden name: Julia Anna
15. Birthplace: ?

16. Informant: Emma Thomas

Address: 242 Bishop Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 8-1949 (month) (day) (year)

Cemetery or crematory: Mt Calvary Cem.

Location: Brooklyn Md

16. Funeral director: Elroy O. Wilson

Address: 1000 Brantley Ave

19. 1/5 (Date rec'd by registrar) 19 49 A. W. Hedrick Jm Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 4 1949, at 12:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 28 1948, to Jan 4 1949 and that I last saw him alive on Jan. 4, 1949

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Arterio-Sclerotic Heart Disease	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R B Lighston M. D. ~~or other~~

Address: 501 Cherry Hill Road Date signed: 1-4-49

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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0144

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1
940

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN EASTPORT, MD. LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN EASTPORT, MD.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1118 BAY RIDGE AVE.	STREET ADDRESS (If rural, give location) 1118 BAY RIDGE AVE.

3. NAME OF DECEASED (Type or Print)	(First) LUCY	(Middle) BREWER	(Last) TYDINGS	4. DATE OF DEATH	(Month) JANUARY	(Day) 11	(Year) 1949
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)	8. DATE OF BIRTH 1892	9. AGE last birthday 57 yrs.	If under 1 year Months 8	Days 25	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) ANNAPOLIS MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A				
13. FATHER'S NAME THOMAS BREWER	14. MOTHER'S MAIDEN NAME EMMA TUERS						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT EDWARD T. TYDINGS					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — 2 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Varicose Veins Bilateral.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 46, 1946, to 1.11, 1949, that I last saw the deceased alive on 1-11-, 1949, and that death occurred at 2 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
[signature]	MD.	Eastport Md	1.12.49.

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)	DATE 1/14/49	NAME OF CEMETERY OR CREMATORY CEDAR BLUFF	LOCATION (City, town, or county) ANNAPOLIS,	(State) MD.
DATE REC'D BY LOCAL REG. Jan. 13, 1949	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR JOHN M. TAYLOR & SON	ADDRESS ANNAPOLIS, MD.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 331 830

CERTIFICATE OF DEATH

0145

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Odenton R F D MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Benjamin (Middle) (Last) Wallace

4. DATE OF DEATH: (Month) Jan (Day) 23 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, ~~DIVORCED~~, (Specify) W

8. DATE OF BIRTH

9. AGE last Birthday: 79 yrs. If under 1 year: Months Days If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): R.R. laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Wallace

14. MOTHER'S MAIDEN NAME: Martha Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: Bessie Wallace

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hypertension, Arteriosclerosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral Hemorrhage

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 20, 1949, to 1-23, 1949, that I last saw the deceased alive on 1-20, 1949, and that death occurred at 6:30 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Thomas Newman M.D. 1-23-49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

Jan. 26, 1949 | Fork Cemetery | Odenton, Md.

DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS

Jan. 26, 1949 | Joyce | J.B. Johnson, Annapolis, Md. P.O. Box 462

RECEIVED
FEB 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

422.2
93d

0146

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos. 21 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 4 mos, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery County

City or town: Mount Zion
(If outside city or town limits, write RURAL and give nearest town)

Street No.: none
(If rural, give LOCATION)

2.(a) If veteran, name war: ******

3. (a) FULL NAME JOHN WEBSTER

3. (b) Social Security Number

4. Sex: MALE

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: ** years

7. Birth date of deceased (mo., day, yr.): 1/17/1895

8. AGE: Years: 53 Months: * Days: 27 If less than one day: ******* min.

9. Birthplace: Maryland town unknown
(Town, county, and state)

10. Usual occupation: farmer

11. Industry or business: none

FATHER
12. Name: Joe Webster
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rose E. Cook
15. Birthplace: Maryland

16. Informant: Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 9 49 (month) (day) (year)

Cemetery or crematory: Mt Zion

Location: Montgomery Co Md

18. Funeral director: Robert L Snowden

Address: Rockville Md

19. 1/17 49 (Date rec'd by registrar) E F Joyce Local Registrar

MEDICAL CERTIFICATION R.M

20. DATE OF DEATH: 1/4/49 1949 at 11:17 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/13/48 19 to 1/4/49 19 and that I last saw him alive on 1/4/49 19

Immediate cause of death: myodegeneratio cordis

Due to

Due to

Other conditions: Senile Psychosis

(Include pregnancy within 3 months of death)

DURATION: known to us since 8/13/48

Major findings of operations: ******

Date of op.

Autopsy results: ******

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: **** Date of))

Where did injury occur? ***** (City or town) (County) *** (State)

Injured at home, farm, industry, public place (where?) *

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D. M. D. or other

Address Date signed

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 10 1949
BUREAU V. S.

0147

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

450.0

CERTIFICATE OF DEATH

93a

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole
LENGTH OF STAY (in this place) 15 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Sarah (Middle) Catherine (Last) Wells

4. DATE OF DEATH (Month) 1 (Day) 9 (Year) 1949

5. SEX Female
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH 9-5-1884
9. AGE last birthday 64 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) South River, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Horace Wheler
14. MOTHER'S MAIDEN NAME Rebecca Wheler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Richard Stevens

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Myo-Carditis — INTERVAL BETWEEN ONSET AND DEATH 2 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio-Sclerosis — 2 years.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Second Degree Burn of Chest

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1948, to Jan 9, 1949, that I last saw the deceased alive on Jan 9, 1949, and that death occurred at 12:40 P m., from the causes and on the date stated above.

SIGNATURE R. L. Richardson MD. (Degree or title) ADDRESS Annapolis, Md. DATE SIGNED 1/10/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 1-12-49
NAME OF CEMETERY OR CREMATORY Brewer Hill
LOCATION (City, town, or county) Annapolis-A.A. (State) Md.

DATE REC'D BY LOCAL REG. Jan. 12 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR William Reese, II
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 13 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

023 × 30e

0148

Reg. Dist. No. 20

1. PLACE OF DEATH COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater P.O. LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater P.O. Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS County Home	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Earle (Middle) G. (?) (Last) West

4. DATE OF DEATH (Month) Jan (Day) 22 (Year) 1949

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W.

8. DATE OF BIRTH 4/24/1871

9. AGE last birthday 77 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) N. Y. State

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If year, give war or dates of service)

16. SOCIAL SECURITY NO. none (?)

17. INFORMANT Supervisor of County Home.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Luetic valvular disease & endarteritis	?
Antecedent cause(s)	(b) Decompensated	2 mos.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Was worked up at Univ. Hosp. Clinic - 1 yr. ago.	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from August, 1947, to Jan 22, 1949, that I last saw the deceased alive on 1/18, 1949, and that death occurred at 3 30 A m., from the causes and on the date stated above.

SIGNATURE M. F. K Lawans, M.D. (Degree or title) ADDRESS Annapolis, Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) DATE Jan 23, 1949 NAME OF CEMETERY OR CREMATORY County Home LOCATION (City, town, or county) Edgewater (State) Md

DATE REC'D BY LOCAL REG. Jan 23, 1949 REGISTRAR'S SIGNATURE Edward Collinson

24. FUNERAL DIRECTOR T A Hardesty & Son ADDRESS Galesville

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 25 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

434.1

0149

CERTIFICATE OF DEATH

938

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (In this place): 6 Mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 43 College Creek Terrace

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Norfolk
STREET ADDRESS (If rural, give location): 721 Brewer Street

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) (Last) White

4. DATE OF DEATH: (Month) 1 (Day) -27- (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Mar. 1889

9. AGE last birthday: 59 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Pennington Chaney

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: abt. 1 mos

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: annapolis (CITY OR TOWN) a 4 (COUNTY) md (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-13, 1948, to 1-27, 1949, that I last saw the deceased alive on 1-24, 1949, and that death occurred at 2 Σ P m., from the causes and on the date stated above.

SIGNATURE: C. T. Allen (Degree or title) ADDRESS: 10 Carroll DATE SIGNED: 1-29-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 1-31-1949 — NAME OF CEMETERY OR CREMATORY: Norfolk — LOCATION (City, town, or county) (State): Norfolk, Virginia

DATE REC'D BY LOCAL REG.: Jan. 29, 1949

REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: Mrs. Charles E. Hicks — ADDRESS: 43-45 Northwest St.

RECEIVED
FEB 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

153
462

0150

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Friendship
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Anne Arundel
City or town: Friendship, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lenea Ellen Wilkerson Wood.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Harold Thomas Wood.
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Dec. 3, 1905

8. AGE:	Years	Months	Days	If less than one day
	43	1	14	hrs. min.

9. Birthplace: Friendship Md.
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: own home.
MOTHER FATHER 12. Name: Richard Wilkerson
13. Birthplace: Fair Haven, Md.
MOTHER 14. Maiden name: Sarah Cornelia Jones
15. Birthplace: Env Marlboro. Md
16. Informant: Mrs Edgar Crowley
Address: Friendship. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 20th 1949 (month) (day) (year)
Cemetery or crematory: Friendship Cem
Location: Friendship
18. Funeral director: Harry Hutchins
Address: Owings - Beall
19. 1/20 1949 M. Clayton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 18 1949 at 6:45a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 10 1948 to Jan 18 1949 and that I last saw h. alive on Jan 7 1949

Immediate cause of death	DURATION
Carcinoma sigmoid flexure of Colon	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma lower end sigmoid metastasis to liver. Date of op. Oct. 16, 1948

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Emily H. Wilson, M.D.
M. D. or other
Address: Lothian, Md. Date signed: 1/18/49.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 20 1949
BUREAU V. S.

0151

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 450.0 / 97

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: 2550 Mace Street (If rural, give LOCATION)

2.(a) If veteran, name war: ~~m~~ ✓

3.(a) FULL NAME: JOHN WOOLFORD

3.(b) Social Security Number:

4. Sex: MALE

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: unknown

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): approx.

8. AGE: Years: 70 Months: Days: If less than one day ..... hrs. ..... min.

9. Birthplace (Town, county, and state): unknown

10. Usual occupation

11. Industry or business

FATHER: 12. Name

13. Birthplace

MOTHER: 14. Maiden name

15. Birthplace

16. Informant: Hospital records

Address: Crownsville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 7th/49 (month) (day) (year)

Cemetery or crematory: Mt Calv. Cemetery

Location: Brookland Md

18. Funeral director: Elroy O Wilson

Address: 1000 Brantley av

19. 1/5 1949 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-2-49 1949 at 4:04 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 23rd 1948, to Jan. 2nd 1949; and that I last saw him alive on Jan. 2nd 1949

Immediate cause of death: Generalized arteriosclerosis

Due to

Due to

Other conditions: Senile psychosis (Include pregnancy within 3 months of death)

DURATION: from to ns since December 23rd-48 and admission

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D. M. D. or other

Address ..... Date signed

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1

0152

CERTIFICATE OF DEATH 92b

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis, — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis,
STREET ADDRESS (If rural give location): 12 Porter Rd U.S. Naval Academy

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Everett	Peter	Wuebbens	January	28	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	8-22-02	46 yrs.	5	6		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chaplain	U.S. Navy	Flanagan, Illinois	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward Wuebbens	Ida Mauman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
Yes	W.W. II	none	Hospital Records, USNH, Annapolis, Marylan

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Massive Mural Thrombus Occluding the Mitral Valve and Extending into Pulmonary Artery

Antecedent cause(s) Coronary Occlusion with Myocardial Infarction

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ____

(c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes XX No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8th Jan. 1949 to 28 Jan. 1949, that I last saw the deceased alive on 28 Jan. 1949, and that death occurred at 9:07 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
G.M. Davis	G.M. Davis, CDR., MC, USN	USNH Annapolis, Maryland	January 28, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	Jan. 31, 1949		Flanagan, Illinois

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 31, 1949	[signature]	Ben L. Hopping and Son	Annapolis, Maryland

RECEIVED
FEB 1 1949
BUREAU V. S.